October 10, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1043.01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. A physician Board Certified in Orthopedic Surgery reviewed your case.

The physician reviewer **AGREES** with the determination of the insurance carrier. The reviewer is of the opinion that a right knee arthroscopy and chondroplasty are **NOT MEDICALLY NECESSARY.**

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC

Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on October 10, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1043-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of right knee arthroscopy and chondroplasty.
2. Correspondence and documentation from the carrier.
3. History and physical examination, office notes, notes from treating physicians and consultants.
4. Physical therapy notes.
5. Reports of various imaging studies (plain x-rays and MRI).

B. BRIEF CLINICAL HISTORY:

The patient, a ___ policeman, fell while chasing a burglar on ___, injuring his knees. He saw his chiropractor the following day, and subsequently other consultants. He had physical therapy, appropriate medications, pain management, and x-ray and MRI studies. He required crutches and a knee

immobilizer early. Examinations even a month later showed evidence of abrasions, swelling, tenderness and loss of motion in his right knee.

C. DISPUTED SERVICES:

The insurance carrier is denying pre-authorization for right knee arthroscopy and chondroplasty.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE. RIGHT KNEE ARTHROSCOPY AND CHONDROPLASTY IS NOT MEDICALLY NECESSARY.

E. RATIONALE OR BASIS FOR DECISION:

There is no evidence that chondroplasty alone, done for early degenerative joint disease, or chondromalacia, prevents progression or causes long-term relief of knee symptoms. However, there are pertinent facts in this case to be considered further:

1. There is clinical evidence of significant injury of the right knee (abrasions, swelling, tenderness, limitation of motion).

2. There is evidence on plain x-rays of early degenerative joint disease of the right knee, and probably of the left knee as well.

3. There is MRI evidence of early degenerative joint disease in the right knee, chondromalacia in the lateral facet of the patella and corresponding lateral femoral condyle; there is also lateral tilt of the patella.

4. There are less definite, but similar changes in the lateral compartment of the left knee, suggesting that this patient has early degenerative joint disease and possible lateral subluxation of the patellae in both knees; right knee symptoms exacerbated by the injury. Further evaluation of the significance of the lateral tilt and early DJD in these knees is indicated before surgery.

5. Suggest additional review of the existing plain x-rays, and MRI (3/25/02), especially by the surgeon to assess the need for related procedures (such as lateral retinacular release) when and if the need for surgery becomes apparent.

6. Physical therapy was helpful initially, but has reached a point of maximum benefit. Both the patient's assessment and the physical therapists' notes suggest a "plateau" of response has been reached, pain level is low, range of motion and limb muscle strength is near normal.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 8 October 2002